MEDICAL BOARD OF CALIFORNIA

JOINT COMMITTEE ON BOARDS, COMMISSIONS, AND CONSUMER PROTECTION

January 2005 Hearing
On The Initial
Report Of The Medical Board Enforcement Monitor

BACKGROUND PAPER

Senator Liz Figueroa
Chair

Senate Members	Assembly Members
Samuel Aanestad	Gloria Negrete-McLeod
Edward Vincent	Paul Koretz
	Todd Spitzer

Joint Committee Staff:
Ed Howard, Chief Consultant
David Link, Vince Marchand, Consultants
Angela Baber, Committee Assistant

BACKGROUND PAPER

INTRODUCTION

The Medical Board of California's ("Board") current enforcement responsibilities were established by the Legislature in 1975 as part of a watershed legislative deal. That deal (i) placed unprecedented restraints on private lawsuits filed to obtain compensation for harm caused by allegedly negligent physicians; and (ii) created a vigorous Board-run enforcement program designed to identify and discipline potentially dangerous physicians.

Enforcement by the Board is far and away the Board's most critical public protection function. Indeed, physician safety and medical quality are among the most tangible and direct regulatory functions state government performs. Virtually everyone in California has contact with doctors and the medical establishment, and can identify the importance of safe medical practices.

An exhaustive sunset review in 2002 revealed numerous and significant problems with the Board's enforcement and public disclosure practices. The Legislature responded by enacting SB 1950 (Figueora).

Among other things, SB 1950 required the Department of Consumer Affairs ("Department") to hire an independent Enforcement Monitor "to monitor and evaluate the disciplinary system and procedures of the [Medical Board], making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system." (Business & Professions Code section 2220.1 (c))

The Department selected Julie D'Angelo Fellmeth of the Center for Public Interest Law as the Monitor, and chose Tom Papageorge of the Los Angeles District Attorney's Office as the Principal Consultant.

SB 1950 also required the Board to undergo sunset review again this year.

In November of 2004, the Monitor issued its 294 page "*Initial Report: Medical Board of California Enforcement Program Monitor*" ("Report"). This hearing is convened to hear testimony about the Report.

As described in more detail below, the Report ("initial" because it is the first of two) identifies serious and ongoing deficiencies in the Board's enforcement program and serious and ongoing deficiencies in the Board's related "diversion" program, which is designed to rehabilitate physicians with drug or alcohol problems.

Finally, the Report provides numerous detailed recommendations for addressing and fixing the many problems identified. Members have been provided a copy of the actual Report, but this Background Paper offers both a summary of its major findings and recommendations and a legislative perspective.

BRIEF BACKGROUND ON "THE DEAL" AND THE VITAL PUBLIC IMPORTANCE OF THE BOARD'S ENFORCEMENT PROGRAM

A. Prior to 1975, The State Relied Primarily Upon Generally Applicable Tort Law Principles to Motivate Physician Competence And Carefulness.

The general rule in California is that everyone has a legal duty to act with due care to avoid foreseeable harms to others and must pay for the damages they cause when, by their negligence, they breach that legal duty. (*See,* e.g., Civil Code section 1714(a): "Everyone is responsible, not only for the result of his or her willful acts, but also for an injury occasioned to another by his or her want of ordinary care or skill in the management of his or her property or person[.]")

In civil tort law, the aim usually is not to punish the negligent actor. In tort law, "responsibility" means personal accountability. It means a responsibility to compensate the victim for the damage done. . In virtually all instances the monetary measure of damages in civil negligence cases is determined and quantified by a jury, based on the evidence a judge allows in during trial.

The California Supreme Court ruled in *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 187 that these general principles of negligence are not written in stone. They are simply a reflection of what decision-makers believe to be the best public policy for the State. This Legislature is as constitutionally empowered to change the principles of general negligence as any other policy, in light of competing priorities or changing wisdom.

Prior to 1975, the former, physician-dominated Board of Medical Examiners had the responsibility of disciplining physicians. This physician-dominated board was by most accounts largely ineffective.

There was little public outcry, however. Prior to 1975, death or injury allegedly caused by the negligence of a physician was treated no differently than harm allegedly caused by any other professional (or anyone else for that matter) under the negligence principles articulated above.

For example, prior to 1975, if a physician negligently driving a car on the way to the office hit an individual, a jury would be free to award the victim the full measure of the victim's damages, including economic losses of lost wages and medical bills and non-economic damages meant to compensate for harm that is real, but not purely financial,

like pain. Likewise, prior to 1975, if a physician negligently caused identical harm to the same person while acting as his doctor, the victim was also legally able to seek and obtain exactly the same damages to compensate him for the same harm.

In essence, then, prior to 1975, California law requiring personal responsibility was the primary way this state helped both to deter patient injury and motivate physician competence. In that sense, "regulation" of physician misconduct was left primarily to the unregulated, market-like, financial incentives of the civil tort system.

B. Soaring Medical Malpractice Insurance Premiums Spark A Political And Public Health Upheaval.

This changed in 1975. In that year, medical malpractice insurers in California announced massive premium increases and sweeping non-renewals. Different people then and now have vastly different judgments about why premiums and non-renewals soared[1], but no one disputes the fact that they were soaring. As the Doctor's Company explains:

> "That year, two malpractice insurance companies made major announcements: one notified 2,000 Southern California physicians that their insurance would not be renewed, and the other notified 4,000 Northern California physicians that their premiums would increase by 380 percent."

(http://www.thedoctors.com/advocacy/micra.asp#3)

These sudden insurance premium increases and non-renewals galvanized California's physician community as never before or since. It is easy to understand why. General negligence principles do not, practically speaking, burden everyone equally. While application of general negligence principles in a single case might not bankrupt a shopkeeper or teller, given what physicians do, that they are human, and humans make errors, insurance for physicians is a practical necessity.

In 1975 physicians were thus unexpectedly confronted with rock and hard place decisions: raise fees to their patients (recall, this was mostly before managed care), eat into their profits, or risk going without coverage. One physician has described the resulting political atmosphere from the physician's perspective this way:

> "A massive reaction of outraged and energized doctors continued for eight months. It quickly created an urgency among legislators, exacerbated by thousands of letters sent by patients at the request of their doctors. They

[1] In essence, physicians and their insurers argue that large increases in both the number of lawsuits and the size of related pay-outs caused the price spike. (http://www.thedoctors.com/advocacy/micra.asp#3) However, consumer groups and the plaintiffs' bar argue that, for example, "As its predecessors, today's insurance 'crisis' has absolutely nothing to do with the U.S. legal system, tort laws, lawyers or juries. It is driven by the insurance underwriting cycle[.]" (http://www.consumerwatchdog.org/healthcare/nw/nw002494.php3)

> demanded relief. Gov. Jerry Brown declared a 'special session' of the California Legislature to handle the liability problem. A brief but emergency-covered 'strike' closed some doctors' offices; a sit-in in the governor's office by doctors' wives, departure of some specialists, busloads of doctor-visitors to the legislature, and endless publicity and arguments in the press, radio and television filled the spring and summer."

(http://www.sfms.org/sfm/sfm303e.htm)

What emerged from the special session was AB 1 (Keene); the "Medical Injury Compensation Reform Act of 1975," commonly referred to as "MICRA."

In the main, MICRA sought to restrain both the number of physician negligence lawsuits and the size of the jury awards by placing then (and still) unprecedented restrictions on the discretion of jurors to compensate victims of physician negligence. The law also imposes what is, in essence, equally unprecedented legal price regulation. Hard percentage caps are imposed in an otherwise unregulated legal marketplace, but only on what medical malpractice lawyers who represent injured patients may lawfully charge for their services.

More specifically, MICRA's major provisions include:

- "A cap of $250,000 on non-economic damages (i.e., pain, suffering, loss of consortium)
- Disclosure to the jury of collateral sources of payment (other sources of health insurance payments for the same injury)
- Limits on attorney fees
- Periodic payments for future damages
- A requirement that plaintiffs give a 90-day warning of an impending claim to the provider so that the provider has a chance to settle the claim out of court
- A strengthened physician discipline system"

(http://www.thedoctors.com/advocacy/micra.asp#3) (Civil Code section 3333.2 et seq.)

Why did the Legislature believe these reforms would reduce the number and size of physician negligence lawsuits? Injured victims of physician negligence rarely have the cash to pay for lawyers who charge by the hour. Indeed, few businesses have such resources; that is why most businesses purchase insurance to help pay the hourly rate legal bills charged by the lawyers who defend them.

So, the only asset most injured patients have that allows them to "buy" quality counsel is the compensation they might obtain for their injuries.

Lawyers who take such cases are called "contingency fee" lawyers because they only earn a fee if they win the case. That fee is based upon a percentage of the uncertain "contingency" of a settlement or a jury verdict in their client's favor. And, because these lawyers risk earning nothing for the time, overhead, and costs they "invest" in a case upfront, they require compensation that reflects their risk, just like any venture capitalist will demand a greater return from a dollar invested in a risky start-up company than a dollar invested in General Electric.

If the Legislature elected to cap the amount of stock a venture capitalist could seek for his investments in start-up widget-making companies, and likewise chose to place a hard dollar cap on the amount of income such widget-makers could earn, it would not be long before those with money to invest would look for other opportunities.

Thus, MICRA did not per se change the general rule that physicians would be liable for the foreseeable harms their negligence caused. Instead, it capped the financial consequences of such negligence, and through this and other means, made physician negligence cases less financially attractive to the plaintiff's bar.

But, recognizing that such measures could result in fewer financial consequences for physicians who fail to act with due care, and that fewer consequences might mean more carelessness[2], AB 1 also abolished the old Board of Medical Examiners and created a new "Board of Medical Quality Assurance" ("BMQA"). The very name of the new Board revealed the Board's new enforcement emphasis. The BMQA consisted of 19 members, seven of them non-physician, public members.

For the first time, a board regulating the medical profession would have a dedicated enforcement arm, called the "Division of Medical Quality," which was (and is) charged with creating and implementing a Board-run enforcement program, including making decisions in license disciplinary matters. Eventually, the BMQA was re-named the Medical Board of California; the name it retains to this day.

This in a nutshell was the essence of "the deal:" in an atmosphere smacking of a public health crisis, the Legislature aimed to ensure the public's utterly essential need for access to physicians and health care "up front" by imposing an unprecedented restraint on the public's "back end" ability to resort to a private, compensatory remedy.

But this trade-off related to a private remedy was also in exchange for the promise of a Board that would have the enduring legal obligation, power, and resources to identify and swiftly discipline potentially dangerous physicians.

---

[2] Which, ironically, could potentially drive up losses and hence premium. Observe that this possibility is especially true when considering patients who are not high wage earners. MICRA does not cap "economic" damages from lost wages or income. Cases involving such wealthier patients were more financially attractive pre-MICRA (larger damage award potential), but by capping the non-economic pain and suffering damages that the less wealthy must use to "buy" counsel, MICRA on its face exacerbates this difference.

BOARD ENFORCEMENT QUICKLY AND PERSISTENTLY COMES UNDER FIRE

The Medical Board has struggled to live up to its necessary responsibilities. Just five years after the "deal," the quality of the Board's enforcement program was already being widely criticized. Throughout the 1980s, the Auditor General, Assembly Office of Research, Little Hoover Commission, and the Legislative Analyst all found serious faults with the Board's enforcement performance. (Report, pp. 22-26)

These serious and ongoing failures were fully documented in 1989, when the Center for Public Interest Law authored a report entitled *Physician Discipline in California: A Code Blue Emergency*. That report examined the history of the Board's many problems and further documented even greater failings in the Board's enforcement program.

The use of the medical term for emergency – "code blue" -- in the title was not an overstatement. The following year, its dire concerns were illustrated in a series of events that sustained the report's core criticisms:

- The public was shocked when Dr. Milos Klvana was sentenced to 53 years in prison for 47 felony counts, including nine counts of the second degree murder of infants. The Board had a history of discipline against Klvana dating back over a decade, but the Board continued to permit him to practice. In 1990, a judge publicly criticized the Board for its failure to discipline Klvana more severely, and asserted that the Board's lax discipline opened the way for the physician to cause the deaths of the nine infants;

- The Legislature discovered the Board had a backlog of almost 900 uninvestigated cases. In response, the Legislature withheld half of the Board's budget until it addressed this unheard of bottleneck, which was preventing the Board from accomplishing its core legislative priority of physician discipline; and

- A national report ranked the Board 42nd among all the states in the number of serious disciplinary actions taken against physicians.

Five years later, in 1994, the *Los Angeles Daily News* published a series of articles on physician negligence that revealed yet more problems with the Board's physician discipline function. The articles included ones titled:

- "*Anatomy of Malpractice Doctors. Insurers Settled $483 Million In Claims From 1990-92. Unknown To Public*"; and

- *"Are The Public's Interests Served? Doctor's Multiple Settlements Not*

Disclosed In Medical Board's Records."

These articles focused on a then little-known problem – $483 million was the amount insurers spent to settle 2,002 medical negligence claims from 1990-1992, without the public ever being able to learn whether their own physician had settled such a claim. The *Daily News* apparently obtained this information by filing a Public Records Act request with the California Highway Patrol, which had been called in to investigate allegations that the Board was improperly destroying documents.

2002 SUNSET REVIEW

As mentioned earlier, the Board was last reviewed by the Joint Committee in 2002. During the first part of that year, the Joint Committee was engaged in a routine review of the Board. But then yet another newspaper series was published, this time in the *Orange County Register*. That series was titled, "*Doctors Without Discipline*," and began on April 7th, 2002.

Those articles focused on the Board's handling of an obstetrician who had allegedly botched deliveries and injured or killed many infants. The series documented:

- an eight-year delay between the Board's 1993 receipt of a report from a hospital about the physician and its 2001 filing of a formal accusation against the physician;

- the Board's failure to seek an interim suspension order against the physician until 2002, despite multiple complaints, investigations, lawsuits, hospital reports, and patient deaths;

- the Board's declining enforcement output;

- the Board's failure to check court files for the filing and outcome of medical malpractice actions;

- the Board's "mandatory" reporting statutes were easily evaded by physicians (and their lawyers) who wished to avoid being reported to Board; and

- the Board's public disclosure policy, where every stakeholder -- medical groups, hospitals, insurers -- was informed of medical negligence settlements, except the one stakeholder who could actually be killed or injured by a physician; namely, patients.

The Joint Committee decided to delay hearing issues related to Board enforcement and public disclosure policies until May 1. This brief delay was to permit Joint Committee staff to investigate the issues raised by the articles, to craft additional recommendations, and to provide ample time for members to question the Board at a hearing devoted solely

to the issues raised by the articles.

The Joint Committee's in-depth investigation in 2002 confirmed – yet again -- serious flaws in the Board's enforcement program. For example:

1. Board complaint and investigative priorities were questionable. "Urgent" complaints received the highest Board investigative priority, but "Quality of Care – Patient Death" and "Quality of Care – Gross Negligence/Incompetence" cases were not classified as "urgent." In contrast, sexual misconduct allegations or a doctor's self-abuse of drugs or alcohol were considered "urgent" even absent any known risk to patients (e.g., doctor on sabbatical) (Observe, one case has defined "gross negligence" as lack of even "scant care or an extreme departure from the ordinary standard of practice." *Yellen v. Board of Medical Quality Assurance* (1985) 172 Cal.App.3d 1040)

2. Every category of board enforcement activity had significantly declined since the last review in 1996, even while complaints from patients had increased.

   - The Board received 10,899 complaints in 2000-2001; apparently a record. This was up from 10,445 complaints in 1999-2000, 10,751 complaints in 1998-1999, and 10,816 in 1997-1998.

   - Accusations filed by the Board had declined.

     1998-1999 = 392
     1999-2000 = 290
     2000-2001 = 256

   - Revocations/surrenders of licenses with accusation pending obtained by the Board had declined.

     1998-1999 = 125
     1999-2000 = 122
     2000-2001 = 88

   - Probations obtained by the Board had declined.

     1998-1999 = 122
     1999-2000 = 126
     2000-2001 = 107

   - Interim Suspension Orders had declined.

     1998-1999 = 31
     1999-2000 = 19
     2000-2001 = 17

3. Few complaints became the basis of a formal investigation. Few formal investigations became the basis of an accusation. Few accusations led to administrative hearings.

    - Only about 20-25% of all complaints to the Board were referred to trained, professional investigators for the possibility of formal disciplinary action.

    - Few formal investigations resulted in referrals to the Attorney General for preparation of a formal accusation (25%) The number of investigations referred to the AG was declining:

      1997-1998 = 676
      1998-1999 = 618
      1999-2000 = 491
      2000-2001 = 510

    - Few formal accusations resulted in a disciplinary hearing.

4. 65-70% of all formal accusations were settled prior to the hearing.

5. 65% of complainants were dissatisfied with the result of their complaint to the Board.

6. The computer system used by the Board's complaint unit investigators did not contain enough detail to know whether a quality of care complaint that came in about the same physician alleged the same or similar kinds of misconduct as prior complaints, prior discipline, prior medical malpractice judgments, settlements or awards. This was essential because two of the statutory grounds for discipline -- "Repeated negligent acts." (B&P Code section 2234(c) and 2234 (d) – require proof of repeat acts)

7. Contrary to law, the Attorney General was routinely consulted by complaint units in personnel only after the determination has been made by complaint unit personnel to send a complaint to an investigator. Government Code section 12529.5 (b) provides: "Attorneys shall be assigned . . .to assist in the evaluation and screening of complaints *from receipt* through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations[.]" (Emphasis added)

8. There was no formal requirement that a Medical Consultant evaluating a complaint must consult with a physician expert in the relevant sub-specialty before the Consultant could recommend that the case be closed.

9. Public confidence in the Board's enforcement program and the transparency of its public disclosure policies was thin and, if possible, getting thinner; there was concern it was on the verge of evolving into a "crisis."

SB 1950 (FIGUEROA)

SB 1950 was enacted during the 2002 legislative session. It addressed these problems by employing a two-step approach. First, the bill sought quickly to address what were the most glaring problems identified by the Joint Committee's investigation. Hence, the bill:

- Established a list of five types of "priority cases" for Board enforcement (with cases involving patient harm prioritized first);

- Required quality of care complaints to be reviewed by a specialist with the "pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint";

- Closed loopholes in the Board's mandatory reporting statutes;

- Authorized the Board for the first time to disclose information about some civil physician negligence settlements;

- Required the Board to be reviewed again in two years rather than the customary four;

- Revised the definition of "repeated negligent acts" to remove legal uncertainty about the term and hence promote it as a grounds for discipline; and

- Revised the Board's composition by adding two new public member positions.

Second, and most pertinently for the current hearing, the bill also created an independent "enforcement monitor" charged with a searching, two year long review of the Board's enforcement programs. It is that Monitor's first Report that is being presented to the Joint Committee.

CURRENT ISSUES

The Monitor's Report points to a myriad of enduring, potentially dangerous, and often interrelated problems that continue to hamper the Board from holding up its end of "the deal." The Monitor makes no less than 65 separate and specific recommendations.

In general, the key problems identified by the Monitor are:

(1) *Enforcement actions take too long*.

The average time for a serious complaint to be finally resolved is 2.63 years. The Board does not have full control over all of this process, but it does have direct control over complaint processing, investigation, and prosecution activities. (See various aspects of the problem discussed in the *Report¸ Chapters V-XII*, pp. 55-204)

If there are legal impediments that the Board cannot control, but are causing such unacceptable delays, one would expect that the Board – charged as it is with one of the most important missions in state government -- would actively identify such barriers and routinely seek legislative fixes.

Yet, the Board has not been especially assertive in requesting such help.

The vast majority of recommendations in the Report address this key problem. For example:

- The state should allow the Board to reinstate lost enforcement positions (Recommendations #1, 26);

- The Board's information systems must be upgraded (Recommendation #3);

- The Board should enforce existing law requiring doctors to turn over medical records a patient has authorized the Board to review (Recommendations #7, 23; see below);

- The Board should take steps to assure that mandatory reporting to the Board by Court Reporters, insurance companies, hospitals and others is accomplished (Recommendations #14, 15, 16);

- The Board should fully implement vertical prosecution (Recommendations #22, 33; see below).

(2) *Physicians who brazenly flout the law cause unnecessary delays in investigations*.

By statute physicians have 15 days from the time they receive a patient's signed release to turn their medical records over to the Board, but physicians routinely flout this legal mandate, and suffer almost no consequences at all for such law-breaking. (Business & Professions Code section 2225).

The average time it takes to get medical records is astonishing, given what the law requires. The Board's Central Complaint Unit takes 66 days, on average – *five times the legal limit* – to obtain the records it needs to adequately assess the complaints the Board receives. (*Report*, p. 140) If a complaint then goes to a full investigation, it takes – again, on average – 74 *additional* days – to get the records necessary for a full and proper investigation. (Ibid.) Thus, it takes an average of 140 days for the Board *just to get medical records* – when the goal set in statute for the *complete investigation* is 180 days.

(Business & Professions Code sec. 2319) And these are just averages; obtaining medical records can take much longer than that.

A core part of the problem is that the Board routinely elects not to enforce the 15 day limit, instead resorting to repeated cajoling and practically empty threats – with the effect discussed above.

This problem can and should be fixed immediately. Because neither investigations nor disciplinary proceedings can (or should) begin without the full medical record having been reviewed, the 15 day legal limit is the foundation of the Board's entire enforcement program.

The Report recommends that the Board should enforce existing law requiring doctors to turn over medical records a patient has authorized the Board to review (Recommendations #7, 23)

Examples of possible remedies not identified in the Report, but which are available and that might both prompt physician compliance and Board enforcement include:

- Making a failure to abide by the 15 day limit a ground for mandatory discipline, including summary and temporary suspension of a license until the records are provided;

- Mandating that the Board pursue legal action after a certain number of days;

- Allowing the Board to obtain its attorneys' fees from a physician to reimburse the Board for the cost of obtaining records from recalcitrant physicians.

(3) *Medical Board resources are inadequate*.

Physicians pay only $300 per year in licensing fees, and have since 1994. The Board is funded solely from a physician license fees, and other funding from the licensees (such as fines). It receives no money from California's General Fund.

Since 1994, the Consumer Price Index has increased by 27.9%, which alone would justify fees at about $382 a year, just so the Board could keep up with the ordinary cost of living increases everyone else notices regularly in their own personal budgets -- not to mention higher wages for its employees. (*Report*, pp. 64-65)

By way of comparison, $382 per year would still be less than California's lawyers annually pay for their practice licenses, which are currently at $390 per year.

But, in addition to simple inflationary factors, the Board's workload has also increased in those ten years. In 1991-92, the Board received 22% fewer complaints than it does today. (*Report*, pp. 66) An additional 22% increase in fees (just to keep up with increased workload) added to the entirely ordinary cost-of-living increases discussed above, would

suggest that an appropriate fee level for today would be about $446 per year. Again, by way of comparison, podiatrists, also medical professionals licensed by the state, but with far fewer responsibilities than M.D.s, pay $450 per year for the licenses to practice. (Business & Professions Code sec. 2499.5 (d))

Yet, as the Report documents, there has been a record of resistance to fee increases by some of the organizations that represent physicians. (*Report*, pp. 64-65) There is apparently such resistance to even a $50 per year increase, which would put the Board less far behind than it currently is, but hardly in a position that is comparable to where it was in 1992. Perspective is important here. An increase of even $100 per year is less than a pair of ski lift tickets for a day in the snow.

Perspective is even more vital on another point:

By 1975 design, the Board performs one of the most important functions in state government. That licensees who enjoy unique legal protections are at the same time represented by powerful organizations that effectively resist modest fee increases required just to keep pace with inflation and higher workloads calls into question – at the roots – whether this Board can ever truly live up to its end of "the deal." It calls into most basic question whether it is wise public policy for patients and the public to rely in any significant way for their safety upon a government-run, but physician-funded, Board.

Indeed, significant reliance upon state government -- no matter the funding source -- is questionable for an additional reason. Not only is the Board hobbled by fees that are practically far lower than they were ten years ago, the Board's enforcement program is further hobbled because of the lasting effects of the statewide hiring freeze that should never have applied to the Board in the first place.

The hiring freeze was imposed on the Board and all of state government by the Governor from 2001-03, and forced the Board in particular to lose almost 45 positions, ***including 29 in their enforcement program alone.*** This was supposedly justified because the state's General Fund faced serious and continuing deficits and was applied to the Board even though the Board obtains no funds at all from the General Fund; even though it is entirely funded by its own "special" fund of licensee fees; even though a dollar saved by a hiring freeze imposed on the Board resulted in no savings at all to the General Fund.[3]

As the Report indicates, the Board is in a kind of financial "perfect storm:" organized physicians defeat legislative proposals that would permit it to raise fees just to keep up with inflation and workloads and a hiring freeze prevented the Board from filling enforcement positions as they became vacant. As well, any future requests for more

[3] As detailed in the Joint Committee's background paper on the cross-cutting issue of the loans Department boards made to the General Fund in 2002 and 2003, there is a critical distinction between independent, fee-supported boards like the Board and any other board, commission or other entity in state government supported by the General Fund. Independent boards are supported solely by fees assessed on their licensees, which are segregated into special funds that are entirely separate from the General Fund.

personnel may be benchmarked not by what the Board actually had pre-freeze, or what it actually needs. Instead, such a request might be compared to the current number of inadequate employees that only exists due to a hiring freeze that should never have been imposed on the Board at all.

The freeze did give the Board an unintended – and fleeting – financial reprieve. With its dramatically declining budget reserves caused by static fees but rising inflation and workloads, the Board's inability to fill vacancies was akin to obtaining an unexpected source of revenue. This, in turn, allowed the Board to pay increases in the hourly rates charged by the Attorney General's office, which have finally gone up after many years from $112 per hour to $139 per hour as of July, 2004, and then will go up again to $146 per hour in July of 2005. This means the Board's expenses for case prosecution will have increased from $6.9 million in 2003-04 to approximately $8.2 million in 2004-05, to $8.7 million in 2005-06. The Board must pay those attorneys out of its own funds, and those costs went up just as the Board's own staff went down.

But now the Board's declining revenues have caught up with it, and the Board is headed for deficits and worse.

The theme of the importance of adequate resources appears on virtually every page of the Initial Report. The Report explicitly states the need to increase fees in Recommendation #2.

(4) *The Board's current prosecution model is not one used by similar public prosecutors, where the lawyers who know which cases are and are not winnable, and what evidence is needed to win, are sensibly brought in at the earliest possible moment to help shape an investigation.*

Many state agencies and most federal agencies require lawyers to work as a team with investigators, with great success. This is called "Vertical Prosecution." The Board still has investigators work up cases by themselves, with occasional review by lawyers; when the investigator thinks the case is ready, he "hands it off" to the prosecuting lawyers, who then must address any legal issues the investigator left undone. (*Report,* Chapter VII)

Vertical prosecution teams allow lawyers and investigators to view each case *as a whole*, rather than as two, separate and independent sequential steps: the investigation and then the prosecution. The problem is an obvious one to anyone who practices this kind (or any other kind) of law – investigating a case and litigating a case are not independent at all; one informs the success or failure of the other. The two are entirely interrelated and interdependent. (Ibid.)

The Attorney General's office is more than familiar with Vertical Prosecution, using it regularly in such areas as Medi-Cal fraud (where the harm is great but not, as here, potentially lethal) The California State Bar (which, one assumes, would be a good judge of such things) also utilizes Vertical Prosecution. In addition, federal prosecutors have relied upon this regulatory prosecution model for years now, with great success in

agencies such as the Federal Trade Commission and the U.S. Department of Justice's Antitrust Division. As the Monitor notes, this model has been recommended to the Board for many years now. (Ibid.)

There is a "compromise" proposal currently in existence, called Deputy in District Office (or DIDO). The program was initially set out in statute in 1990, but was not implemented until six years later. Under this program, attorneys work part-time in Board district offices, and can help investigators work up cases. (*Report*, pp. 123-24)

However, this program falls far short of true Vertical Prosecution. As the Report notes, the half-measure has many flaws, and has not delivered the true benefits that Vertical Prosecution would. (*Report*, p. 131)

The Report clearly and repeatedly recommends implementation of the Vertical Prosecution Model. (See, e.g. Recommendations #22, 33)

(5) *There are serious problems with the Board's diversion program*.

Rather than discipline physicians with substance abuse problems, the Board allows them secretly to enter a Diversion Program to try and address their problem. The Board's position is one of compassion to the affected physicians, since it attempts to allow them to work on curing the problem they have without being disciplined by the Board. (*Report*, Chapter XV, pp. 235-290)

In contrast, other health related boards, such as the Board of Psychology, have no such programs. At those boards, substance abuse, like other problems, can be a cause for ordinary discipline, and is not treated by a separate disciplinary (or, in the case of the Board's Diversion Program, non-disciplinary) system. Rather, each licensee's case is reviewed on its own merits, and discipline imposed – or not – accordingly.

By allowing substance-abusing physicians in recovery to continue in practice, there is a quite obvious potential for danger to the public. Substance abuse is a disease that is especially subject to backsliding, as virtually every responsible recovery program acknowledges.

Such dangers can be minimized by effective monitoring programs. The key, however, is that the monitoring truly be "effective." In the Report, the Monitor examines many cases in the Diversion Program where monitoring utterly fails – from problems with the mechanism of random urine testing, to a lack of personnel to staff the monitoring, to workplace monitors who are at-will employees of the very physicians in the diversion program. (*Report*, pp. 254-85)

Because of chronic understaffing and a budget that barely qualifies as sub-adequate, the Board's diversion program presents serious questions of public safety.

- The program's most important monitoring functions are failing. Urine testing is easy to evade, recordkeeping is spotty at best, and contractors who perform these tasks are far from consistent.

- The program is understaffed and dramatically under funded. During the last ten years, the program has had a 22% increase in participants, and no increase in staff. Caseworkers who are supposed to be monitoring physicians are overloaded, and can barely keep up; frequently do not keep up.

- The program lacks clear and enforceable rules.

CONCLUSION

The Monitor's Report bears out the conclusion that state regulation of physicians in California is at a crossroads.

There is some hope that the Board has now begun to make the necessary commitment to effective and vigorous enforcement. The new Executive Officer not only understands enforcement, he comes from the world of enforcement.

This is progress at an important level. But virtually none of the most serious problems discussed here can be solved with commitment alone. The Board's other true emergency – a lack of resources – must also be addressed. The Board is now headed into serious deficit, and has already been warned by the Department it must craft a remedy immediately.

The Board does not receive General Fund money to supplement its budget, and it has virtually no programs or personnel that can be cut without utterly crippling its already meager and freeze-depleted functions. Either the Board must be effectively crippled or license fees must be increased, and they must be increased substantially – to bring physicians up to par with other licensed professionals, both within the medical world (like podiatrists) and outside it (such as lawyers).

If this and the other reforms highlighted cannot be accomplished even after the detailed and thorough findings of the Report, California's system of physician regulation can be expected to free fall into crisis, where the Legislature's decision in 1975 to place significant reliance upon government-imposed remedies rather than private ones will be questioned.

Voters in other states are exploring other, more creative forms of physician discipline. Last year, for example, about seventy percent of the voters in Florida passed Amendment 8. That Amendment says, in part, that "No person who has been found to have committed three or more incidents of medical malpractice shall be licensed or continue to be licensed by the State of Florida to provide health care services as a medical doctor." California has not yet gone down this road of bypassing the discretion of its Medical Board.

The Report suggests the Board is aware of its central role is enforcement, and has the desire to stake its reputation on that goal. All stakeholders have a deep interest in making sure that California's Board finally lives up to the role it has been assigned, and is not just adequately serving the public's trust, but is the best in the nation.